STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION

HEALTH CARE & BENEFITS DIVISION

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Dear Fellow State of Montana Health Plan Member,

The State of Montana Health Care & Benefits Division offers a ***Tobacco Cessation*** benefit to employees! The Tobacco Cessation Program is designed to assist employees who are ready to quit using tobacco. Studies have shown the highest rate of success is achieved through a combination of counseling and use of a tobacco cessation medication (as necessary). Studies also show that it takes several tries for most tobacco users to quit for good, and more relapses occur when someone is not truly ready to make this change.

This benefit helps defray the costs of tobacco cessation-related health care costs and prescriptions. **It is a once-in-a-lifetime, one year benefit. Be sure you are ready to quit for good.** Expenses that occur prior to approval or after one year will not be reimbursed.

Successful applicants will first access the services available through the Montana Tobacco Quit Line. The Quit Line is available for help quitting tobacco even if you choose not to participate in the Tobacco Cessation Program. *For more information on the Quit Line's services, please contact them at 1-800-QUIT-NOW (784-8669) or visit www.tobaccofree.mt.gov.* When additional services are needed, the benefit works by waiving the co-payments and/or co-insurance for approved in-network tobacco cessation-related medical services and/or prescriptions billed through the State of Montana medical or prescription plans.

To participate in this program, please review the attached program guidelines and complete the attached contract. Return the completed contract to the Health Care and Benefits Division. Applicants agree, at a minimum, to work with the Montana Tobacco Quit Line and a case manager from the Health Care and Benefits Division during the course of this benefit.

We look forward to working with you to help you be tobacco free! If you have any questions please contact our office.

Sincerely,

State of Montana Department of Administration
Health Care & Benefits Division
PO Box 200130
Helena, MT 59620-0130

(406) 444-7462 (in Helena)
(800) 287-8266 (Toll Free)
QuitNow@mt.gov

Tobacco Cessation Program Guidelines

The Tobacco Cessation Program is offered to tobacco users who want to quit, and are insured with the State of Montana Health Care Plan.

1. This is a once-in-a-lifetime, one-year benefit. You have one year from the date you start to use this benefit. Expenses that occur prior to approval or after one year will not be reimbursed.
2. Participants will work with the program case manager from Health Care and Benefits.
3. Participants must use the Quit Line telephone tobacco cessation coaching at least once per month during the duration of this benefit.
4. As requirements are met, the benefit works by waiving pre-authorized, in-network co-payments and/or co-insurance for tobacco cessation-related medical services and/or prescriptions billed through the State of Montana plan.
5. The number of plan dollars available through this benefit is limited and usage will be closely monitored by the program case manager, who will work with you to determine the best course of action for your success.

Examples of Reimbursable Products and Services: *Must be preauthorized.*

- Co-payments and/or co-insurance for visits with in-network health care providers for tobacco cessation for up to four tobacco cessation-related health care provider visits.
- Face-to-face tobacco cessation counseling **if** first accessed through the EAP.

For those with a prescription, 18 years or older:

- Over the Counter (OTC) Nicotine Replacement Therapy (NRT), **if** the two weeks provided by the Quit Line is used first.
- Chantix - you will be responsible for first two $50 co-payments through the Quit Line, after which the benefit covers up to four additional months.
- Bupropion - Wellbutrin, Zyban, etc.

If you are ready to quit and willing to comply with the program guidelines, please continue on to fill out the Tobacco Cessation Program Contract.

TOBACCO CESSATION PROGRAM CONTRACT

Please answer each question below. Partially completed contracts will be returned.

1. Name: Date of Birth: / /
2. Telephone Number: ( ) E-mail:
3. Mailing Address:

4. Are you a participant on the State of Montana Health Care Plan? Yes ☐ No ☐
   If yes, Policy Holder Name: Health Plan ID:
5. Do you currently use tobacco products? Yes ☐ No ☐
6. If so, what do you use and how often?
   Cigarettes ☐ How often? Spit Tobacco ☐ How often?
7. How long have you used tobacco products?

8. Have you ever tried to quit using tobacco? Yes ☐ No ☐
   If yes, what methods have you used to try to quit using tobacco?
   If yes, what was the longest span of time you were able to quit?

9. How ready are <u>you</u> to quit using tobacco? Circle the number that best reflects how you feel.

   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
   Not ready Somewhat ready Ready Ready Right Now!

10. Are you trying to quit because someone else, not yourself, wants you to quit?
    Yes ☐ No ☐ If yes, please briefly explain:

11. Please designate a cessation champion for yourself. This is someone in your life who supports your decision and will support you as you face this challenge. This person must agree to be contacted, if necessary, following program completion.
    a. Cessation Champion Name:
    b. Cessation Champion Telephone: ( )
    c. Cessation Champion E-mail:

This is a voluntary program. I understand this is a once-in-a-lifetime, one-year benefit and I must be covered by the State of Montana health care plan to qualify. Expenses that occur prior to approval or after one year will not be reimbursed. This benefit may be terminated if I do not comply with the program requirements. By authorizing this form, I agree to case management coordination for qualifying expenses. I authorize the Montana Tobacco Quit Line to provide verification of my participation in health coaching to Health Care and Benefits. *This information will ONLY include the number of times I contact the Quit Line per month.* I may revoke this authorization at any time. I agree to be contacted to provide more information following program completion. I understand that all my personal information will be kept entirely confidential.

Signature: _____ Date:

Please return this form to the Health Care and Benefits Division; Fax: (406) 444-0080 or Mail: PO Box 200130, Helena, MT 59620-0130. *Upon receipt of this application, we will contact you to discuss the program options and answer any questions you may have within two weeks (14 business days).*